

out of necessity, choose his career blindly. The student who says, "I want to be a doctor," usually has only booklets and counselors to accommodate his inquiries. While such sources are indeed helpful, only fragments of knowledge can be obtained from them. The ultimate opportunity is to work at his chosen field; to be there, to see, to experience for oneself the reality of medicine.

At seventeen years of age, I was privileged to witness that which is otherwise unavailable to students until the third year of medical school. There is no way to measure the knowledge received from having participated in this program. I have gained such insight pertaining to the field of medicine that I feel absolutely confident in making a decision. And for me, that decision is to become a physician.

It is my sincere hope that physicians throughout the United States will recognize this program for the valuable concept it is, and perhaps apply a similar one to other areas. Future physicians will be indebted to you for years to come, as I am indebted to Dr. Harris and the staff at General Hospital, Ventura, California.

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EDITOR'S NOTE: Subsequent to acceptance of the above letter by the JOURNAL, the author informed us that he had submitted it to several publications. It also has been accepted for publication by the *Journal of the American Medical Association*.

## Physician Supply in California

TO THE EDITOR: The study, "Physician Supply in California" (Western Journal of Medicine 123: 250-253, Sep 1975), reports information that might mislead the reader. It suggests that there is no California physician shortage but instead only a physician maldistribution, the suburban areas growing most while the rural areas are static or contract in the ratio of doctors to population.

The fact to be remembered at all times is that in a free uncontrolled society, shortage in any commodity is always first shown by maldistribution.

For example, no one now complains about the shortage of barbers. However, if one eliminated 20 percent of all barbers evenly throughout in Los Angeles County, in a little while, Beverly Hills, La Canada and Granada Hills will still be close to saturated while Watts, Bell Gardens and Pacoima would have lost most of their barbers—

since barbers will move to the most rewarding areas by preference.

Doctors will also choose the most satisfying place to work—urban high income areas—during a time of increasing shortage of doctors as we now have. Why should they choose a ghetto, or a low income rural area where the shortage permits them to practice in the affluent more rewarding areas?

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## Continuing Medical Education in Smaller Hospitals

TO THE EDITOR: Dr. Block's prescription for continuing medical education (CME) programs in a small community hospital [123:154-158, August 1975] arouses mixed feelings.

The initial reaction is one of pride in his achievement, and commendation to his medical staff, for CME resources in a meaningful, accessible pattern. Particularly the specialty meetings, where limited attendance involved participants to their benefit. His reference list is a real service for all programmers.

Next came a feeling of déjà vu: hasn't all this been going on for years in community hospitals throughout the nation? At least since the Joint Commission for Accreditation of Hospitals (JCAH) started applying its Standard VI on CME to its surveys. Some staffs of very small, remote hospitals have even formed consortia for this purpose.<sup>1</sup>

Then came a sense of opportunities still to be realized. "Continuing education" is a concept of personalized learning for a professional career. Medical staff members should review their individual activities, to see where their time, money and effort have been invested, to discover their unmet needs, and to plan ahead for better activities. The annual report forms from the California Medical Association (CMA) and the American Academy of Family Physicians provide this opportunity. It will show a major time investment in reading, although many of us cannot keep up with our own subscriptions. The JCAH survey specifically recommends a hospital library, which may also include tapes, films and the Medical Skills Library.<sup>2</sup> To get more involvement from "guest speakers," have them consult and comment on presentations of local cases. If the team ap-

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proach to hospital care is indeed a reality, nurses and technicians should also participate in conferences. Teaching is an opportunity for CME no matter where a hospital is located, for there are always paramedicals, patients and public to be informed. Medical students are available to practitioner-preceptors through year-round Family Practice electives and through the summertime CMERF-SCOPE [California Medical Education and Research Foundation-Student Community Orientation and Preceptorship Education] project.

Penultimately, a word about the patient care audit. It is not advertised as the answer to CME programs, but as a logical way to help make CME programs relevant to medical practice. Current emphasis is because of its novelty and potential to education based on patient care. Effective use of audit, taking full advantage of each step, reveals this method to be an education in itself. Participation on an audit committee or in a staff ratification or report session can be basic CME. If an education program is additionally advisable, its content and methodology are evident. "Slavish adherence" to any method makes no sense, but neither does passive data transfer to an

uninvolved audience. Keeping up with new facts may not be so important to practice as problem-solving techniques and appropriate use of existing services.

And finally to continuing staff education itself. Many part-time and full-time directors of medical education belong to a national organization, the Association for Hospital Medical Education (AHME), which provides ideas, experience and guidelines for hospital CME. Consultation on programs can be directly from the CMA and its accreditation program, or from the AHME<sup>3</sup> through its regional representatives. Principles of CME apply to all community hospitals, small and large. The focus remains on individual practitioners, their learning styles and their needs for patient care.

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### REFERENCES

1. Zuckerman SL: Tri-hospital associations. *AHME Journal* 5: 29, 1972
2. Medical Skills Library, 12 categorical films designed by the American College of Physicians, and sold by ROCOM, Nutley, NJ 07110
3. Association for Hospital Medical Education (AHME), 1911 Jefferson Davis Highway—Suite 905, Arlington, VA 22202; phone (703) 521-1133

## Gonococcal Arthritis

Because of the increase in the late diagnosis of gonorrhea, gonococcal arthritis is becoming a problem. At the University of Washington in 103 cases of undiagnosed arthritis, 25 percent had probably disseminated gonococcal infection. Pharyngeal infection and menstruation appeared to be associated with the dissemination of the infection to the joints. And this is a pretty typical kind of arthritis . . .

—ROBERT A. H. KINCH, MD, *Montreal*  
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